		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040956

Facility Name: The Wealshire

Address: 150 Jamestown Lane (Number) Lincolnshire (City) 60069 (Zip Code)

County: Lake

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9029

IDPA ID Number: 36-3952069

Date of Initial License for Current Owners: 8/14/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/29/01 (Date)
(Type or Print Name) Arnold Goldberg
(Title) President

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd., Suite 300, Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/17/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	24	Skilled (SNF)	24	8,784	1
2		Skilled Pediatric (SNF/PED)			2
3	88	Intermediate (ICF)	98	35,108	3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	22	8,812	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		8,000		8,000	8
9	SNF/PED					9
10	ICF	1,095	30,905		32,000	10
11	ICF/DD					11
12	SC		7,058		7,058	12
13	DD 16 OR LESS					13
14	TOTALS	1,095	45,963		47,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.29%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Daycare

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/14/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/14/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	276,866	35,806	8,998	321,670		321,670		321,670			1
2	Food Purchase		276,706		276,706	(11,697)	265,009	(9,918)	255,091			2
3	Housekeeping	311,952	221	34,430	346,603		346,603		346,603			3
4	Laundry	66,807		15,333	82,140		82,140		82,140			4
5	Heat and Other Utilities			189,530	189,530		189,530		189,530			5
6	Maintenance	77,167		105,823	182,990		182,990	1,445	184,435			6
7	Other (specify):*											7
8	**TOTAL General Services**	732,792	312,733	354,114	1,399,639	(11,697)	1,387,942	(8,473)	1,379,469			8
	B. Health Care and Programs											
9	Medical Director			48,333	48,333		48,333		48,333			9
10	Nursing and Medical Records	2,827,996	126,524	8,435	2,962,955		2,962,955	(23,254)	2,939,701			10
10a	Therapy	56,575	359	5,849	62,783		62,783		62,783			10a
11	Activities	280,678	20,687	27,981	329,346		329,346		329,346			11
12	Social Services	105,219		5,363	110,582		110,582		110,582			12
13	Nurse Aide Training											13
14	Program Transportation			8,395	8,395		8,395	(8,395)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,270,468	147,570	104,356	3,522,394		3,522,394	(31,649)	3,490,745			16
	C. General Administration											
17	Administrative	51,565		367,000	418,565		418,565	1,654	420,219			17
18	Directors Fees											18
19	Professional Services			59,856	59,856		59,856	31,048	90,904			19
20	Dues, Fees, Subscriptions & Promotions			157,843	157,843		157,843	(125,377)	32,466			20
21	Clerical & General Office Expenses	207,179	10,724	112,384	330,287		330,287	33,399	363,686			21
22	Employee Benefits & Payroll Taxes			544,062	544,062	11,697	555,759		555,759			22
23	Inservice Training & Education			11,029	11,029		11,029	(11,029)				23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,004	9,004		9,004	(7,018)	1,986			25
26	Insurance-Prop.Liab.Malpractice			47,665	47,665		47,665	39,375	87,040			26
27	Other (specify):*							13,924	13,924			27
28	**TOTAL General Administration**	258,744	10,724	1,308,843	1,578,311	11,697	1,590,008	(24,024)	1,565,984			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,262,004	471,027	1,767,313	6,500,344		6,500,344	(64,146)	6,436,198			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Wealshire #0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			54,118	54,118		54,118	702,935	757,053			30
31	Amortization of Pre-Op. & Org.							59,399	59,399			31
32	Interest			1,548	1,548		1,548	1,255,370	1,256,918			32
33	Real Estate Taxes							110,000	110,000			33
34	Rent-Facility & Grounds			2,660,000	2,660,000		2,660,000	(2,660,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,715,666	2,715,666		2,715,666	(532,296)	2,183,370			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			73,681	73,681		73,681	(73,681)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,838	65,838		65,838		65,838			42
43	Other (specify):*	100,873		3,680	104,553		104,553	(104,553)				43
44	**TOTAL Special Cost Centers**	100,873		143,199	244,072		244,072	(178,234)	65,838			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,362,877	471,027	4,626,178	9,460,082		9,460,082	(774,676)	8,685,406			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(57)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128,514	30		9
10	Interest and Other Investment Income	(4,930)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,703)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(9,228)	21		17
18	Fines and Penalties	(580)	20		18
19	Entertainment				19
20	Contributions	(10,817)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(43,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,919)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(70,223)	20		28
29	Other-Attach Schedule	(285,526)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (306,002)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(468,674)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (468,674)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (774,676)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Wealshire

ID# **0040956**

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 800	6	1
2	Marketing Salary	(100,873)	43	2
3	Marketing Expense	(3,680)	43	3
4	Nursing Income	(1,220)	10	4
5	Health Study Income	(2,000)	10	5
6	Medical Record Fees	(106)	10	6
7	Beauty Shop Income	(73,681)	40	7
8	Massage Therapy Revenue	(19,928)	10	8
9	Resident Outings Revenue	(8,395)	14	9
10	Food Rebates	(7,158)	2	10
11	Out of period legal expense	(6,534)	19	11
12	COPE contributions	(224)	20	12
13	Contributions - LPLP	(13,160)	20	13
14	Non-allowable Insurance - LPLP	(5,586)	26	14
15	Business Gifts - LPLP	(1,950)	21	15
16	Non-allowable Auto Exp. - LPLP	(422)	25	16
17	Non-allowable depreciation	(4,358)	30	17
18	Current Year Deferred Maint	(4,800)	6	18
19	Nonallowable auto expense	(7,018)	25	19
20	Nonallowable meal expense	(3,537)	21	20
21	Nonallowable legal expense (Hinsdale Property)	(667)	19	21
22	Undetailed Expense	(11,029)	23	22
23	Mgnt Fees Lincolnshire property	(10,000)	17	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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37				37
38				38
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(285,526)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,918)	0	0	0	0	0	0	0	0	0	0	(9,918)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,000)	5,445	0	0	0	0	0	0	0	0	0	1,445	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,918)	5,445	0	0	0	0	0	0	0	0	0	(8,473)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(23,254)	0	0	0	0	0	0	0	0	0	0	(23,254)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(8,395)	0	0	0	0	0	0	0	0	0	0	(8,395)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(31,649)	0	0	0	0	0	0	0	0	0	0	(31,649)	16
	C. General Administration													
17	Administrative	(10,000)	10,000	1,654	0	0	0	0	0	0	0	0	1,654	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,201)	29,736	8,513	0	0	0	0	0	0	0	0	31,048	19
20	Fees, Subscriptions & Promotions	(138,537)	13,160	0	0	0	0	0	0	0	0	0	(125,377)	20
21	Clerical & General Office Expenses	(21,634)	(39,013)	94,046	0	0	0	0	0	0	0	0	33,399	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(11,029)	0	0	0	0	0	0	0	0	0	0	(11,029)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(7,440)	422	0	0	0	0	0	0	0	0	0	(7,018)	25
26	Insurance-Prop.Liab.Malpractice	(5,586)	44,961	0	0	0	0	0	0	0	0	0	39,375	26
27	Other (specify):*	0	0	13,924	0	0	0	0	0	0	0	0	13,924	27
28	**TOTAL General Administration**	(201,427)	59,266	118,137	0	0	0	0	0	0	0	0	(24,024)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(246,994)	64,711	118,137	0	0	0	0	0	0	0	0	(64,146)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Wealshire # 0040956 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	124,156	578,779	0	0	0	0	0	0	0	0	0	702,935	30
31	Amortization of Pre-Op. & Org.	0	59,399	0	0	0	0	0	0	0	0	0	59,399	31
32	Interest	(4,930)	1,260,300	0	0	0	0	0	0	0	0	0	1,255,370	32
33	Real Estate Taxes	0	110,000	0	0	0	0	0	0	0	0	0	110,000	33
34	Rent-Facility & Grounds	0	(2,660,000)	0	0	0	0	0	0	0	0	0	(2,660,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	119,226	(651,522)	0	0	0	0	0	0	0	0	0	(532,296)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(73,681)	0	0	0	0	0	0	0	0	0	0	(73,681)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(104,553)	0	0	0	0	0	0	0	0	0	0	(104,553)	43
44	**TOTAL Special Cost Centers**	(178,234)	0	0	0	0	0	0	0	0	0	0	(178,234)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(306,002)	(586,811)	118,137	0	0	0	0	0	0	0	0	(774,676)	45

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Arnold Goldberg	99%			Lincolnshire Prop. LP	Lincolnshire	Bldg Partnership
Wealshire Inc.	1%			Alexander Blake & Co	Skokie	Mgmt Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 2,660,000	Lincolnshire Properties LP		$	$ (2,660,000)	1
2	V	21	Misc. Income	41,220	Lincolnshire Properties LP			(41,220)	2
3	V	17	Management Fees		Lincolnshire Properties LP		10,000	10,000	3
4	V	20	Contributions		Lincolnshire Properties LP		13,160	13,160	4
5	V	21	Office Expense		Lincolnshire Properties LP		2,207	2,207	5
6	V	26	Insurance		Lincolnshire Properties LP		44,961	44,961	6
7	V	19	Professional Fees		Lincolnshire Properties LP		29,736	29,736	7
8	V	25	Auto Expenses		Lincolnshire Properties LP		422	422	8
9	V	33	Real Estate Tax		Lincolnshire Properties LP		110,000	110,000	9
10	V	6	Repairs & Maintenance		Lincolnshire Properties LP		5,445	5,445	10
11	V	32	Interest Expense		Lincolnshire Properties LP		1,260,300	1,260,300	11
12	V	30	Depreciation		Lincolnshire Properties LP		578,779	578,779	12
13	V	31	Amortization				59,399	59,399	13
14	Total			$ 2,701,220			$ 2,114,409	$ * (586,811)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 377,000	Alexander Blake, & Co.		$	$ (377,000)	15
16	V	17	Salary - A. Goldberg		Alexander Blake, & Co.		300,000	300,000	16
17	V	17	Salary - Administrator - Jennifer Loughney		Alexander Blake, & Co.		78,654	78,654	17
18	V	21	Salary - Office		Alexander Blake, & Co.		90,784	90,784	18
19	V	27	Payroll Taxes		Alexander Blake, & Co.		13,924	13,924	19
20	V	19	Professional Fees		Alexander Blake, & Co.		8,513	8,513	20
21	V	21	Clerical expense		Alexander Blake, & Co.		3,262	3,262	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 377,000			$ 495,137	$ * 118,137	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Arnold Goldberg	Administrator	Administrative	99.00	None	37	75.00	Salary	$ 2,089	17-1	1
2								Salary	300,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 302,089		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Equity Bank		X	Vehicle Loan	$425.92	5/8/00	$ 17,071	$ 10,023	5/8/01	9.0000	$ 1,548	1
2	Diawa Finance Corp		X	Mortgage	$129,285.00	10/31/97	16,000,000	15,375,740	10/31/07	8.1500	1,260,300	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$129,710.92		$ 16,017,071	$ 15,385,763			$ 1,261,848	9
	B. Non-Facility Related*											
10											(4,930)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,930)	14
15	TOTALS (line 9+line14)						$ 16,017,071	$ 15,385,763			$ 1,256,918	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	107,637	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	107,637	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	110,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	110,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	59,779	8
	1996	99,017	9
	1997	97,230	10
	1998	106,006	11
	1999	107,637	12

accrual=1999 tax x 1.02%

$107,637 x 1.02 = $109,790 (rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 709,360 2. Number of Years Over Which it is Being Amortized: 10

3. Current Period Amortization: 59,399 4. Dates Incurred: 1997

Nature of Costs: Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 970,925	1
2					2
3	TOTALS			$ 970,925	3

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144			1995	$ 11,521,031	$ 416,569	35	$ 576,052	$ 159,483	$ 3,096,279	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	34,126	875	20	1,706	831	8,858	9
10	CARPET			1996	1,500	38	20	75	37	344	10
11	FLAGS & POLES			1996	1,954	50	20	98	48	433	11
12	FLAGS & POLES			1996	605	16	20	30	14	130	12
13	ALARM SYSTEM			1999	9,183	235	20	459	224	586	13
14	SECURITY SYSTEM			1999	4,427	114	20	221	107	264	14
15	VARIOUS			2000	8,664	120	20	252	132	252	15
16	CABLING			2000	2,639	37	20	77	40	77	16
17	WINDOW REPLACEMENTS			2000	625	9	20	18	9	18	17
18	CABINETS & TOPS			2000	6,360	88	20	186	98	186	18
19	COLUMBIA AUDIO & VIDEO			2000	1,582	22	20	46	24	46	19
20	PHONE CABLING			2000	1,402	19	20	41	22	41	20
21	LUMBER			2000	633	9	20	19	10	19	21
22	IRRIGATION SYSTEM			2000	920	13	20	27	14	27	22
23	BORIS BARBARIC			2000	950	13	20	28	15	28	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				55,358	3,625		2,712	(913)	4,749	35
36	TOTAL (lines 4 thru 35)				$ 11,651,959	$ 421,852		$ 582,047	$ 160,195	$ 3,112,337	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WHIRLPOOL			1997	2,475	309	20	124	(185)	496	9
10	ATASH FIRE			1997	7,116	889	20	356	(533)	1,305	10
11	SIDEWALK			1999	4,660	443	20	233	(210)	272	11
12	MUSIC SYSTEM			1999	33,003	846	20	1,650	804	1,994	12
13	WALLPAPER & CARPETING			1998	3,993	766	20	200	(566)	533	13
14	SIGN			2000	1,611	15	20	34	19	34	14
15	MUSIC SYSTEM			2000	2,500	357	20	115	(242)	115	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 55,358	$ 3,625		$ 2,712	$ (913)	$ 4,749	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,579,254	$ 189,375	$ 164,279	$ (25,096)		$ 797,920	37
38	Current Year Purchases	64,922	12,889	6,164	(6,725)		6,164	38
39	Fully Depreciated Assets	30,188	1,057	1,057			30,188	39
40								40
41	TOTALS	$ 1,674,364	$ 203,321	$ 171,500	$ (31,821)		$ 834,272	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Use	Limo	1998	$ 17,530	$ 3,366	$ 3,506	$ 140	5	$ 10,226	42
43										43
44										44
45										45
46	TOTALS			$ 17,530	$ 3,366	$ 3,506	$ 140		$ 10,226	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 14,314,778	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 628,539	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 757,053	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 128,514	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,956,835	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	LANDSCAPING 1996	$ 43,000	$ 2,867	$ 12,902	52
53	Completion of Building 1996	58,161	1,491	6,772	53
54					54
55					55
56					56
57	TOTALS	$ 101,161	$ 4,358	$ 19,674	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,711	$ 263,771	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	156,677	178,480	3
4	Supply Inventory (priced at)	38,690	38,690	4
5	Short-Term Investments			5
6	Prepaid Insurance	70,467	70,467	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	8,640		8
9	Other(specify): See supplemental schedule	10	40,840	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 290,195	$ 592,249	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,142,280	13
14	Buildings, at Historical Cost		16,003,892	14
15	Leasehold Improvements, at Historical Cost	75,569	214,393	15
16	Equipment, at Historical Cost	343,280	1,709,591	16
17	Accumulated Depreciation (book methods)	(247,838)	(3,346,675)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		405,890	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,000	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 171,011	$ 18,130,371	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 461,206	$ 18,722,619	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 521,103	$ 522,063	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	187,461	187,461	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	314,534	314,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,908	16,908	31
32	Accrued Real Estate Taxes(Sch.IX-B)		110,000	32
33	Accrued Interest Payable		85,830	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	47,619	47,619	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,087,625	$ 1,284,415	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,023	10,023	39
40	Mortgage Payable		15,375,740	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,023	$ 15,385,763	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,097,648	$ 16,670,178	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (636,442)	$ 2,052,442	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 461,206	$ 18,722,620	48

***(See instructions.)**

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (393,531)	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (393,531)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(242,911)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (242,911)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (636,442)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,965,465	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,965,465	3
	B. Ancillary Revenue		
4	Day Care	8,550	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,910	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,460	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	100,366	13
14	Non-Patient Meals	57	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,850	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,124	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 122,397	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,930	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,930	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	113,919	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 113,919	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,217,171	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,399,639	31
32	Health Care	3,522,394	32
33	General Administration	1,578,311	33
	B. Capital Expense		
34	Ownership	2,715,666	34
	C. Ancillary Expense		
35	Special Cost Centers	178,234	35
36	Provider Participation Fee	65,838	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,460,082	40
41	**Income before Income Taxes (line 30 minus line 40)****	(242,911)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (242,911)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,672	2,080	$ 70,244	$ 33.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,945	40,028	856,111	21.39	3
4	Licensed Practical Nurses	9,951	10,537	189,746	18.01	4
5	Nurse Aides & Orderlies	116,975	124,661	1,469,606	11.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,550	3,717	56,575	15.22	8
9	Activity Director	240	240	3,665	15.27	9
10	Activity Assistants	22,401	24,213	277,012	11.44	10
11	Social Service Workers	3,932	5,516	105,219	19.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,254	26,988	276,866	10.26	15
16	Dishwashers					16
17	Maintenance Workers	4,162	4,569	77,167	16.89	17
18	Housekeepers	33,323	36,213	311,952	8.61	18
19	Laundry	7,749	8,596	66,807	7.77	19
20	Administrator	376	400	14,110	35.28	20
21	Assistant Administrator	1,024	1,200	35,367	29.47	21
22	Other Administrative	67	67	2,089	31.18	22
23	Office Manager	1,364	1,696	33,619	19.82	23
24	Clerical	10,409	11,312	173,560	15.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,090	1,263	17,840	14.13	31
32	Other Health Care(specify)					32
33	Other(specify)	10,705	12,192	325,320	26.68	33
34	TOTAL (lines 1 - 33)	291,189	315,488	$ 4,362,875 *	$ 13.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,998	1-3	35
36	Medical Director	Monthly	48,333	9-3	36
37	Medical Records Consultant	Monthly	3,360	10-3	37
38	Nurse Consultant	233	2,325	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	117	5,849	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	as needed	7,560	11-3	44
45	Social Service Consultant	100	5,363	12-3	45
46	Other(specify) Massage Therapy	as needed	19,928	10-3	46
47	Alzheimer Consultant	as needed	2,750	10-3	47
48	Music Therapist	as needed	493	11-3	48
49	TOTAL (lines 35 - 48)	450	$ 104,959		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arnold Goldberg	Executive Director	99%	$ 2,089
Jennifer Loughney	Administrator	0%	12,021
Annette LoCasio	Asst. Admin	0%	37,456
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,566

B. Administrative - Other

Description	Amount
Alexander Blake & Co. - Management Fees	$ 367,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 367,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 10,265
Leonard Manewith	Accounting	750
Cole Assoc.	Accounting	1,000
Ash, Amos, Freedman & Logan	Legal	7,201
see attached	computer consulting	26,980
Community Care Alternatives	Other consultants	2,864
AMG Corp	Accounting	1,000
Personnel Planners	Unemployment Consultant	844
Checkers Simon	Accounting	1,752
Konaster	Accounting	6,400
Achieve Accreditation	Other consultants	800
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,856

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,153
Unemployment Compensation Insurance	13,404
FICA Taxes	332,190
Employee Health Insurance	102,691
Employee Meals	11,697
Illinois Municipal Retirement Fund (IMRF)*	
Misc Employee Benefits	16,837
401k Expenses	38,787
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,759

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	22,259
Health Care Worker Background Check	610
(Indicate # of checks performed 61)	
Licenses & Permits	2,128
Dues & Subscriptions	7,269
Yellow Page Advertising	70,223
Advertising & Promotion	43,533
Less: Public Relations Expense	( )
Non-allowable advertising	(43,533)
Yellow page advertising	(70,223)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,466

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Paving Parking Lot	2000	$ 4,800	3	$	$	$	$ 800	$ 1,600	$ 1,600	$ 800	$	$
2													
3													
4													
5													
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17													
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19													
20	TOTALS		$ 4,800		$	$	$	$ 800	$ 1,600	$ 1,600	$ 800	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Council on LT Care: 4413**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,359** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,978**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,697** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **57**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.